Patient Care Information

Hillside Dental

Name ________________________________ ❑ Male ❑ Female
LAST FIRST MIDDLE

Birth Date ____________________ Please Check ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Student Status ❑ High School ❑ College/Technical College ❑ Part Time ❑ Full Time Where? ____________

Home Phone ____________ Cell Phone ____________ Social Security # ____________

Home Address ________________________________
STREET CITY STATE ZIP

Business Address ________________________________
STREET CITY STATE ZIP

Home E-mail Address ____________ Business E-mail Address ____________

Employer ____________ Business Phone ____________ Present Position ____________

Name of Spouse ____________ Cell Phone ____________ Names of Children ____________

Spouse's Employer ____________ Business Phone ____________ Present Position ____________

Name of person to notify in an emergency ________________________________

Relationship ____________ Phone ____________

Address ________________________________
STREET CITY STATE ZIP

Previous Dentist ____________ Last Seen ____________

Address ____________ Phone ____________
STREET CITY STATE ZIP

Physician's Name ____________ Clinic Name ____________ Last Seen ____________

Address ____________ Phone ____________
STREET CITY STATE ZIP

Person responsible for my account ____________ Social Security # ____________

Name(s) of other family members seen here ________________________________

Whom may we thank for this referral? ________________________________

For Patients with Dental Insurance

Primary Insurance ____________ Subscriber's Name ____________

Subscriber's Employer ____________ Subscriber's Soc. Sec. # ____________ Subscriber's Birth Date ____________

Name of Insurance Plan ____________ Group # ____________

Insurance Plan Address ________________________________
STREET CITY STATE ZIP

Secondary Insurance ____________ Subscriber's Name ____________

Subscriber's Employer ____________ Subscriber's Soc. Sec. # ____________ Subscriber's Birth Date ____________

Name of Insurance Plan ____________ Group # ____________

Insurance Plan Address ________________________________
STREET CITY STATE ZIP

Orientation - Dental History

Providing you with comprehensive care in a calm and comforting environment is our greatest concern. It is an important part of our philosophy to understand your needs, values, and concerns. For this reason, we ask you to please share the following information about yourself.

1. Your approximate age at first dental appointment ____________
2. Was care regular? ❑ Yes ❑ No
3. How much decay did you have as a child? ❑ A lot ❑ Average ❑ Very little
4. What are/were your parents dental conditions and care habits? ____________
5. Describe the last five years of your dental care ____________
6. Have you ever had:
   orthodontic treatment? ❑ Yes ❑ No
   oral surgery? ❑ Yes ❑ No
   your bite adjusted? ❑ Yes ❑ No
   root canal treatment? ❑ Yes ❑ No
7. Do you experience sensitivity to heat, cold or pressure? ❑ Yes ❑ No
8. Does food get caught between your teeth? ❑ Yes ❑ No
9. Do you brush your teeth: ❑ Vigorously ❑ Moderately ❑ Lightly
10. How often do you brush your teeth? ____________
11. How often do you floss your teeth? ____________
12. Have you ever had professional instructions in home care? ❑ Yes ❑ No
13. Habits - Do you:
    clench your teeth during the day? ❑ Yes ❑ No
    clench your teeth during the night? ❑ Yes ❑ No
    bite your lips or cheeks regularly? ❑ Yes ❑ No
    hold foreign objects with your teeth? (pencils, fingernails, pipe, etc.) ❑ Yes ❑ No
    mouth breathe while awake or asleep? ❑ Yes ❑ No
    chew tobacco? ❑ Never used ❑ Former user ❑ Current user How often? ____________
    smoke? ❑ Never used ❑ Former user ❑ Current user What form? ____________ How often? ____________
    consume alcohol daily? ❑ Yes ❑ No
14. Problems of the jaw - Have you ever experienced:
    clicking of the jaw? ❑ Yes ❑ No
    pain (joint, ear, side of face)? ❑ Yes ❑ No
    difficulty in chewing? ❑ Yes ❑ No
    chronic neck or shoulder pain? ❑ Yes ❑ No
    chronic headahes? ❑ Yes ❑ No

15. Have you noticed any loosening of your teeth? ❑ Yes ❑ No

16. Do you suffer from pain and/or swelling of your gums? ❑ Yes ❑ No Any pus around the gums? ❑ Yes ❑ No

17. Do your gums often bleed when you floss or brush your teeth? ❑ Yes ❑ No

18. Have you ever suspected you have mouth odor? ❑ Yes ❑ No

19. Have you ever heard of periodontal disease? ❑ Yes ❑ No

20. Do you have any missing teeth? ❑ Yes ❑ No

How long have they been missing? ______________________________

Why didn't you have them replaced? ______________________________

Was it ever suggested? ______________________________

21. Can sugar be found frequently in your daily diet? ❑ Yes ❑ No

Is it consumed with meals? ❑ Yes ❑ No

Is it consumed between meals? ❑ Yes ❑ No

22. Do you take a daily vitamin supplement? ❑ Yes ❑ No Please describe ______________________________

23. Do you eat a balanced diet? ❑ Yes ❑ No

24. How can we help you? (i.e. your expectations, needs, concerns) What is important to you? What are you looking for in a dental office?

Expectations ______________________________

Needs ______________________________

Concerns ______________________________

25. Do you think dental disease is active or controlled in your teeth and tissues? ❑ Active ❑ Controlled

26. Is your general health a value of yours? ❑ Yes ❑ No

27. How would you rate your present general health? (1 = Poor, 10 = Good) 1 2 3 4 5 6 7 8 9 10

Why? ______________________________

28. How would you rate your present dental health? (1 = Poor, 10 = Good) 1 2 3 4 5 6 7 8 9 10

Why? ______________________________

29. Have you ever had any particularly good or bad experiences in dentistry? Please explain ______________________________

____

30. Do you have any dental anxieties? ❑ Yes ❑ No Please explain ______________________________

31. Do you go to a dentist to be cared for, to learn to become more healthy, or both? ❑ Cared for ❑ More healthy ❑ Both

32. If you were given a magic wand and could change anything about your smile and/or dental health what would it be?

____

33. What are your dental health goals 5 to 10 years from now and for the rest of your life?

____

34. In your opinion, what prevents you from achieving your dental health goals?

____

35. Has a dental team ever helped you set up a plan so you could be succesful with your dental goals? ❑ Yes ❑ No

36. How do you enjoy spending your free time? ______________________________

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Medical History

1. Do you feel you are in good health? ❑ Yes ❑ No

   Has there been any change in your general health in the past year? ❑ Yes ❑ No

   If so, please explain ____________________

2. When was your last physical? ____________________

3. Are you under the care of a physician? ❑ Yes ❑ No

4. The following conditions may need pre-medication before dental procedures. Please check any of the conditions that apply to you now or have in the past.
   - ❑ Heart murmur
   - ❑ Mitro valve prolapse
   - ❑ Artificial valve
   - ❑ Rheumatic fever
   - ❑ Artificial joint prosthesis
   - ❑ Surgery with pins
   - ❑ Open heart surgery

5. Please check any of the following that apply to you now or have in the past.
   - ❑ Heart disease
   - ❑ Depression
   - ❑ Abnormal blood pressure
   - ❑ AIDS/ARC
   - ❑ Kidney trouble
   - ❑ Glaucoma
   - ❑ Alcoholism
   - ❑ Drug addiction
   - ❑ Recreational drugs/substances
   - ❑ Hay fever
   - ❑ Tuberculosis
   - ❑ Diabetes
   - ❑ Blood relatives with diabetes
   - ❑ Anemia
   - ❑ Cancer
   - ❑ Transplant surgery
   - ❑ Excessive urination or thirst
   - ❑ Nervous disorder
   - ❑ Seizures
   - ❑ Hepatitis A
   - ❑ Hepatitis B
   - ❑ Hepatitis C
   - ❑ Bruise easily
   - ❑ Asthma
   - ❑ Epilepsy
   - ❑ Radiation therapy
   - ❑ Counseling
   - ❑ Jaundice
   - ❑ Abnormal bleeding
   - ❑ Blood transfusion
   - ❑ Emphysema
   - ❑ Arthritis
   - ❑ Osteopenia/Osteoporosis
   - ❑ Fainting spells
   - ❑ Venereal disease
   - ❑ Pacemaker
   - ❑ Ulcers
   - ❑ Tumor
   - ❑ Other ____________
   - ❑ Other ____________

6. Please check any of the following medications you are taking.
   - ❑ Antibiotics or sulfa drugs
   - ❑ Anticoagulants (blood thinners)
   - ❑ Medication for high blood pressure
   - ❑ MAO inhibitors (i.e. Marplan, Nardil, Parnar)
   - ❑ Antidepressants (i.e. Prozac, Lithium, Tegrel)
   - ❑ Insulin, Tolbutamide (orinase or similar drug)
   - ❑ Vitamins/Herbal Supplements
   - ❑ Digitalis or drug for heart trouble
   - ❑ Nitroglycerin
   - ❑ Antihistamine
   - ❑ Birth control pill
   - ❑ Steroids
   - ❑ Tranquilizers
   - ❑ Aspirin

   List medications

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   ____

   ____

   ____

7. Please check if you are allergic to any of the following:
   - ❑ Local anesthetics
   - ❑ Penicillin or other antibiotics
   - ❑ Iodine, seafood
   - ❑ Sulfa drugs
   - ❑ Aspirin
   - ❑ Barbiturates, sedatives or sleeping pills
   - ❑ Codeine, other narcotics
   - ❑ Latex
   - ❑ Sunscreen
   - ❑ Bi-Sulfites
   - ❑ Other

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8. (Women) Are you pregnant? ❑ Yes, due date is ____________ ❑ No

9. Have you had serious trouble associated with previous dental treatment? ❑ Yes ❑ No If so please explain.

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10. Please check the following on tobacco usage.
    ❑ Never used ❑ Former user ❑ Current user What form? ____________ How often? ____________

Signature ____________________ **Date** ____________

Signature ____________ Date ____________ | Signature ____________ Date ____________

Signature ____________ Date ____________ | Signature ____________ Date ____________